AUTHORIZATION FOR RELEASE OF INFORMATION

To: (*print name and address of business)*

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I, *(print name)*_____, authorize and direct you, to release any and all records in your possession that contain information related to my identity, as requested by the Wisconsin Office of Privacy Protection. Copies of records shall be sent to the Wisconsin Office of Privacy Protection, P.O. Box 8911, Madison, Wisconsin 53708-8911.

The Wisconsin Office of Privacy Protection, and other cooperating law enforcement agencies, will use this information to investigate my complaint of Identity Theft.

I understand that, as a victim of Identity Theft, I am entitled to obtain copies of records that contain information related to the fraudulent use of my identity, and to direct that copies of these records be sent to any federal, state, or local law enforcement agency I specify, in accordance with the federal Fair Credit Reporting Act (FCRA, 15 U.S.C. 1681 et seq.).

A copy of this authorization shall be as valid as the original. This authorization shall be valid for a period of one year from the date it is signed.

Signed _____ Dated _____

Address *(print)* _____